SERFF Tracking #: NCMC-129207841 State Tracking #: NCMC-129207841

Company Tracking #: IL13015

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Illinois Rate/Rule Manual (INITIAL) 03/2014 **Project Name/Number:** IL R/R Manual 03/2014/IL R/R Manual 03/2014

Filing at a Glance

Company: NORCAL Mutual Insurance Company

Product Name: Illinois Rate/Rule Manual (INITIAL) 03/2014

State: Illinois

TOI: 11.2 Med Mal-Claims Made Only

Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations

Filing Type: Rate/Rule
Date Submitted: 09/17/2013

SERFF Tr Num: NCMC-129207841

SERFF Status: Closed-Filed

State Tr Num: NCMC-129207841

State Status:

Co Tr Num: IL13015

Effective Date 04/01/2014

Requested (New):

Effective Date 04/01/2014

Requested (Renewal):

Author(s): Jane Cundiff

Reviewer(s): Gayle Neuman (primary), Julie Rachford

Disposition Date: 12/09/2013

Disposition Status: Filed

Effective Date (New): 04/01/2014 Effective Date (Renewal): 04/01/2014

State Filing Description:

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Illinois Rate/Rule Manual (INITIAL) 03/2014 **Project Name/Number:** IL R/R Manual 03/2014/IL R/R Manual 03/2014

General Information

Project Name: IL R/R Manual 03/2014 Status of Filing in Domicile: Project Number: IL R/R Manual 03/2014 Domicile Status Comments:

Reference Organization: Medicus Insurance Company Reference Number:
Reference Title: Advisory Org. Circular:

Filing Status Changed: 12/09/2013

State Status Changed: Deemer Date:

Created By: Jane Cundiff Submitted By: Jane Cundiff

Corresponding Filing Tracking Number:

Filing Description:

NORCAL Mutual Insurance Company acquired Medicus Insurance Company in October 2011. For the purpose of this filing, NORCAL will use the IL Department of Insurance already approved Rates and Rules submitted by Medicus Insurance Company for your review. Please see the Cover Letter/Explanatory Memorandum under the Supporting Documents tab for further information on this "Me Too" filing.

Company and Contact

Filing Contact Information

Jane Cundiff, Regulatory Compliance jcundiff@medicusins.com

Analyst

6034 West Courtyard Drive 512-879-5128 [Phone]

Suite 310

Austin, TX 78730

Filing Company Information

NORCAL Mutual Insurance CoCode: 33200 State of Domicile: California Company Group Code: 1282 Company Type: Commercial

560 Davis Street Group Name: Med Grp Holdings & Medical Malpractice

Suite 200 Aff State ID Number:

San Francisco, CA 94111 FEIN Number: 94-2301054

(800) 652-1051 ext. 2101[Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No

Fee Explanation:

Per Company: Yes

CompanyAmountDate ProcessedTransaction #NORCAL Mutual Insurance Company\$50.0009/17/201374133923

State Specific

Filing Company:

NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Illinois Rate/Rule Manual (INITIAL) 03/2014 **Project Name/Number:** IL R/R Manual 03/2014/IL R/R Manual 03/2014

Illinois

State:

Refer to our checklists prior to submitting filing (http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm).: OK Refer to our updated (04/06/2007) SERFF General Instructions prior to submitting filing. They have been updated to clarify what rates and rules are required to be filed as well as what rates and rules are not required to be filed. Also, the "Product Name" is the Filing Title and not the Project Number.: OK

NO RATES and/or RULES ARE REQUIRED TO BE FILED FOR LINES OF COVERAGE SUCH AS COMMERCIAL AUTO (except taxicabs), BURGLARY AND THEFT, GLASS, FIDELITY, SURETY, COMMERCIAL GENERAL LIABLITY, CROP HAIL, COMMERCIAL PROPERTY, DIRECTORS AND OFFICERS, ERRORS AND OMMISSIONS, COMMERCIAL MULTI PERIL just to mention a few. However, a Summary Sheet (RF-3) is required to be filed. Please refer to the State Specific Field below for what rates/rules are required to be filed and to our checklists for specific statutes, regulations, etc.: http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp.: OK

Medical Malpractice rates/rules may now be submitted using SERFF effective January 1, 2012.: OK

The only rates and/or rules that are required to be filed are Homeowners, Mobile Homeowners, Dwelling Fire and Allied Lines, Workers' Compensation, Liquor Liability, Private Passenger Automobiles, Taxicabs, Motorcycles and Group Inland Marine Insurance which only applies to insurance involving personal property owned by, being purchased by or pledged as collateral by individuals, and not used in any business, trade or profession per Regulation Part 2302 which says in part, "each company shall file with the Director of Insurance each rate, rule and minimum premium before it is used in the State of Illinois.": OK When selecting a form filing type for a multiple form filing, use the dominant type from these choices: APP - application; CER - certificate; COF - coverage form; DPS - declaration page; END - endorsement; POJ - policy jacket; ORG - Companies adopting an Advisory or Rating Organization's filing. Example: If you are submitting a policy as well as endorsements, a declaration page and an application, you would select "POL" for policy.: OK

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name:Illinois Rate/Rule Manual (INITIAL) 03/2014Project Name/Number:IL R/R Manual 03/2014/IL R/R Manual 03/2014

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Gayle Neuman	12/09/2013	12/09/2013

Objection Letters and Response Letters

Objection Letters Response Letters

Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Kathi Frye	10/30/2013	10/30/2013	Jane Cundiff	10/31/2013	10/31/2013

Filing Notes

9				
Subject	Note Type	Created By	Created On	Date Submitted
Effective Date	Note To Reviewer	Jane Cundiff	12/09/2013	12/09/2013
effective date	Note To Filer	Gayle Neuman	12/09/2013	12/09/2013
status 12/3/13	Note To Filer	Gayle Neuman	12/03/2013	12/03/2013
Status update	Note To Reviewer	Jane Cundiff	12/02/2013	12/02/2013
Actuarial Review	Reviewer Note	Julie Rachford	12/06/2013	

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name:Illinois Rate/Rule Manual (INITIAL) 03/2014Project Name/Number:IL R/R Manual 03/2014/IL R/R Manual 03/2014

Disposition

Disposition Date: 12/09/2013 Effective Date (New): 04/01/2014 Effective Date (Renewal): 04/01/2014

Status: Filed

Comment:

	Overall %	Overall %	Written Premium	Number of Policy	Written	Maximum %	Minimum %
Company	Indicated	Rate	Change for	Holders Affected	Premium for	Change	Change
Name:	Change:	Impact:	this Program:	for this Program:	this Program:	(where req'd):	(where req'd):
NORCAL Mutual	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document	Certification		Yes
Supporting Document	Manual		Yes
Supporting Document	Request to Maintain Data as Trade Secret Information		Yes
Rate	Illinois Rate/Rule Manual 03/2014		Yes

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Illinois Rate/Rule Manual (INITIAL) 03/2014 **Project Name/Number:** IL R/R Manual 03/2014/IL R/R Manual 03/2014

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/30/2013
Submitted Date 10/30/2013
Respond By Date 11/13/2013

Dear Jane Cundiff,

Introduction:

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

Objection 1

Comments: Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?

Conclusion:

Sign up to get e-mail notification for updates to the Department's website. http://insurance.illinois.gov/RSS/

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me. Sincerely,

Kathi Frye

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Illinois Rate/Rule Manual (INITIAL) 03/2014 **Project Name/Number:** IL R/R Manual 03/2014/IL R/R Manual 03/2014

Response Letter

Response Letter Status Submitted to State

Response Letter Date 10/31/2013 Submitted Date 10/31/2013

Dear Gayle Neuman,

Introduction:

Response 1

Comments:

NORCAL is committed to adhering to any governmentally required statistical reporting outlet. At this time, NORCAL will maintain its own plan for statistical reporting of medical malpractice data.

Related Objection 1

Comments: Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Please let us know if we can provide any further information.

Thank you,

Jane Cundiff

Sincerely,

Jane Cundiff

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Illinois Rate/Rule Manual (INITIAL) 03/2014 **Project Name/Number:** IL R/R Manual 03/2014/IL R/R Manual 03/2014

Note To Reviewer

Created By:

Jane Cundiff on 12/09/2013 09:30 AM

Last Edited By:

Gayle Neuman

Submitted On:

12/09/2013 09:52 AM

Subject:

Effective Date

Comments:

Dear Ms. Neuman,

I went ahead and did a post submission update requesting a 4/1/2014 effective date.

Many thanks,

Jane

State:IllinoisFiling Company:NORCAL Mutual Insurance CompanyTOI/Sub-TOI:11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Illinois Rate/Rule Manual (INITIAL) 03/2014 **Project Name/Number:** IL R/R Manual 03/2014/IL R/R Manual 03/2014

Note To Filer

Created By:

Gayle Neuman on 12/09/2013 08:44 AM

Last Edited By:

Gayle Neuman

Submitted On:

12/09/2013 09:52 AM

Subject:

effective date

Comments:

The Department of Insurance has now completed its review of this filing. Originally, you requested the filing be effective March 1, 2014. Please confirm that is the date you wish to use. Your prompt response is appreciated.

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Illinois Rate/Rule Manual (INITIAL) 03/2014 **Project Name/Number:** IL R/R Manual 03/2014/IL R/R Manual 03/2014

Note To Filer

Created By:

Gayle Neuman on 12/03/2013 09:02 AM

Last Edited By:

Gayle Neuman

Submitted On:

12/09/2013 09:52 AM

Subject:

status 12/3/13

Comments:

I am awaiting the review of this filing by the Actuarial Unit.

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Illinois Rate/Rule Manual (INITIAL) 03/2014 **Project Name/Number:** IL R/R Manual 03/2014/IL R/R Manual 03/2014

Note To Reviewer

Created By:

Jane Cundiff on 12/02/2013 12:51 PM

Last Edited By:

Gayle Neuman

Submitted On:

12/09/2013 09:52 AM

Subject:

Status update

Comments:

Dear Ms. Frye,

We just want to make sure that you don't need anything else from us at this time regarding this filing? Many thanks,

Jane Cundiff

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Illinois Rate/Rule Manual (INITIAL) 03/2014 **Project Name/Number:** IL R/R Manual 03/2014/IL R/R Manual 03/2014

Reviewer Note

Created By:

Julie Rachford on 12/06/2013 12:18 PM

Last Edited By:

Gayle Neuman

Submitted On:

12/09/2013 09:52 AM

Subject:

Actuarial Review

Comments:

Actuarial review complete.

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name:Illinois Rate/Rule Manual (INITIAL) 03/2014Project Name/Number:IL R/R Manual 03/2014/IL R/R Manual 03/2014

Post Submission Update Request Processed On 12/09/2013

Status: Allowed

Created By: Jane Cundiff
Processed By: Gayle Neuman

Comments:

General Information:

Field NameRequested ChangePrior ValueEffective Date Requested (New)04/01/201403/01/2014Effective Date Requested (Renew)04/01/201403/01/2014

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name:Illinois Rate/Rule Manual (INITIAL) 03/2014Project Name/Number:IL R/R Manual 03/2014/IL R/R Manual 03/2014

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type: %

Overall Percentage of Last Rate Revision: %

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

			• •				
	Overall %	Overall %	Written Premium	Number of Policy	Written	Maximum %	Minimum %
Company	Indicated	Rate	Change for	Holders Affected	Premium for	Change	Change
Name:	Change:	Impact:	this Program:	for this Program:	this Program:	(where req'd):	(where req'd):
NORCAL Mutual Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

 SERFF Tracking #:
 NCMC-129207841
 State Tracking #:
 NCMC-129207841
 Company Tracking #:
 IL13015

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name:Illinois Rate/Rule Manual (INITIAL) 03/2014Project Name/Number:IL R/R Manual 03/2014/IL R/R Manual 03/2014

Rate/Rule Schedule

Item	Schedule Item				Previous State	
No.	Status	Exhibit Name	Rule # or Page #	Rate Action	Filing Number	Attachments
1		Illinois Rate/Rule Manual 03/2014		New		IL Manual 03-2014 (N) (FINAL).pdf



MANUAL

SECTION I

GENERAL RULES

I. PURPOSE OF MANUAL

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

II. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short-term policy period.

III. LOCATION OF PRACTICE

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. Consideration will be given to insureds practicing in more than one rating territory and/or state. The Territory Definitions are:

1. Counties: Cook, Jackson, Madison, St. Clair and Will

2. County: Vermilion

3. Counties: Kane, Lake, McHenry and Winnebago

4. Counties: DuPage, Kankakee and Macon

5. Counties: Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle

and Randolph

III. LOCATION OF PRACTICE (Continued)

6. Counties: Grundy and Sangamon

7. Counties: Adams, Knox, Peoria and Rock Island

8. Remainder of State

IV. PREMIUM COMPUTATION

- A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.
- B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

V. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

VI. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

- A. Any amount involving \$.50 or over shall be rounded up to the next highest whole dollar amount; and
- B. Any amount involving \$.49 or less shall be rounded down to the next lowest whole dollar amount.

VII. ADDITIONAL PREMIUM CHARGES

- A. Prorate all changes requiring additional premium.
- B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

VIII. RETURN PREMIUM FOR MID-TERM CHANGES

- A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.
- B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.
- C. Retain the Policy Minimum Premium.

IX. POLICY CANCELLATIONS

- A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:
 - 1. A policy is canceled at the Company's request.
 - 2. The Insured is leaving a group practice, or
 - 3. Death, disability or retirement of the Insured.
- B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.
- C. Retain the Policy Minimum Premium when the Insured requests cancellation except when coverage is canceled as of the inception date.

X. POLICY MINIMUM PREMIUM

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of \$500.

Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

XI. PREMIUM PAYMENT PLAN

The Company offers the Insured the choice to pay in full or the following premium payment options:

- A. The monthly premium payment plan requires a minimum of 12.5% of the total premium to be paid on or before the inception/renewal date of the policy and the policyholder is billed 10 monthly installments of 8.33% and a final installment of 4.17%.
- B. The quarterly payment plan requires a 25% down payment and 3 quarterly installments of 25%.
- C. Our Automated Clearing House (ACH) option allows the Insured to have 12 equal monthly installments.

There are no extra fees associated with any premium payment plan.

XII. COVERAGE

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverage will be rated under Standard Claims-Made Rates.

XIII. LIMITS OF LIABILITY

The Basic Limits of Liability are \$1,000,000 per claim/\$3,000,000 annual aggregate. Credits and/or debits apply only to the \$1M/\$3M layer of the Limits of Liability

Individual Limits of Liability will be modified by the Increased Limits factor as applicable for the respective insureds and used to develop the applicable premium.

Liability Limit Factors					
Limits Physicians Surgeons					
\$500K/\$1M	0.719	0.719			
\$1M/\$3M	1.00	1.00			
\$2M/\$4M	1.36	1.55			
\$3M/\$5M	1.52	1.73			

XIV. PRIOR ACTS COVERAGE

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the Insured, subject to underwriting.

XV. EXTENDED REPORTING PERIOD COVERAGE

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

- A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.
- B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.
- C. The premium for the Extended Reporting Endorsement shall be the following Extended Reporting Endorsement rating factors applied to the premium found in Section III:

XV. EXTENDED REPORTING PERIOD COVERAGE (Continued)

1. The Extended Reporting Endorsement factor from the table below is applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

Year	Factor
First Year	3.30
Second Year	3.15
Third Year	2.40
Fourth Year	2.00

- 2. For First Year Claims Made step, it is applied pro-rata.
- 3. For Second Year and all years of maturity, it is applied to the last year's (365 days) annualized premium from the date of cancellation.
- D. Premium is fully earned and must be paid in accordance with state statutes, promptly when due.
- E. The length of the Extended Reporting Period will be indefinite.
- F. Requirements for Waiver of Premium for Extended Reporting Period Coverage.
 - Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.
 - 2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the Insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.
 - 3. The Reporting Period is unlimited.

- END OF SECTION I-

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. DEFINITION

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

Professional Corporations, Partnerships and Associations

- B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:
 - 1. Are comprised of two or more physicians;
 - 2. Are organized as a legal entity;
 - 3. Maintain common facilities (including multiple locations) and support personnel; and
 - 4. Maintain medical/dental records of patients of the group as a historical record of patient care.

II. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations, limited liability companies, or other entity may be written with a separate limit of liability and shall be computed in the following manner:

The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. In order for the entity to be eligible for coverage, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company, and the remaining physicians must be insured by another professional liability program acceptable to the company.

II. PREMIUM COMPUTATION (Continued)

Number of Insureds	Percentages
1	25%
2-5	12%
6-9	10%
10-19	9%
20-49	7%
50 or more	5%

B. Vicarious Liability Charge: For each employed physician and ancillary staff not individually insured by the Company, a premium charge will be made at the same separate corporate percentage rate calculated above, to the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.

III. PREMIUM MODIFICATIONS

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III.

Physician & Surgeons	+/- 25%
Healthcare Providers	+/- 25%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers found in Section III.

- END OF SECTION II-

SECTION III

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

I. <u>CLASSIFICATIONS</u>

- A. Physicians/Surgeons and Non Physician Health Care Providers
 - 1. Each medical practitioner is assigned a rate class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.
 - 2. The rate classes are found in Section III of this Manual.

B. Locum Tenens Physician

- 1. Coverage for a physician substituting for an insured physician will be limited to cover <u>only</u> professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.
- 2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
- 3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

I. CLASSIFICATIONS (Continued)

D. Slot Rating

- Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those Insureds moving through the slot or position.
- The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.
- 3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Company.

E. Per-Patient Visit Rating

- 1. Per-patient visit ratings are offered for Emergency Medicine and Urgent Care physicians.
- 2. The premium for the per-patient volume rated policy is determined by multiplying the appropriate premium for the specialty, the retroactive date, and the limits times the conversion factor indicated in the table below (this product is rounded to the nearest penny) times the annual patients visits. This number is then multiplied by (1 + the applicable corporate rate percentage outlined in Section II). The resulting product is the total premium for the policy.
- 3. Annual patient visits are reported by the Insured based on their actual historical visits, and projected for the next term. Annual patient visits are subject to audit and reconciliation at the end of the policy term.
- 4. The conversion factor below was determined by dividing one by the average patient visits for physicians in the specialty.

Specialty	Conversion Factor
Urgent Care	.000160
Emergency Medicine	.000278

5. Waiver of premium for the Extended Reporting Endorsement does not apply to the Per-Patient Visit Rating.

II. PREMIUM COMPUTATION DETAILS

A. Specialty Class Plan

The following classification plan shall be used to determine the appropriate rating class for each individual Insured.

Physician/Surgeon Specialty	Code	Class
Administrative Medicine	8901	2
Aerospace Medicine	9166	2
Allergy and Immunology	9108	1
Anesthesiology	8903	6
Anesthesiology (Pain Management)	9167	6
Cardiology (Minor Surgery)	9168	8
Cardiology (No Surgery)	9169	3
Colon and Rectal Surgery	8910	11
Critical Care Medicine	9022	8
Dentistry (All Other)	9171	3
Dermatology (Minor Surgery)	9042	3
Dermatology (No Surgery)	9043	2
Emergency Medicine (with Trauma)	9172	12
Emergency Medicine	9044	10
Endocrinology (Surgery)	9243	12
Endocrinology (Minor Surgery)	9122	4
Endocrinology	9013	2
Family Medicine (Including Obstetrics and C-Sections)	9262	18
Family Medicine (Minor Surgery)	9110	9
Family Medicine (No Surgery)	9109	3
Family Medicine (Major Surgery including Obstetrics)	9113	12
Gastroenterology (Minor Surgery)	9174	8
Gastroenterology	8915	5
General Surgery	8919	15
Geriatrics (Major Surgery)	9177	13
Geriatrics (Minor Surgery)	9175	7
Geriatrics (No Surgery)	9176	3
Gynecology (Major Surgery)	9128	12
Gynecology (Minor Surgery)	9066	8
Gynecology (No Surgery)	9067	4
Hand Surgery	9027	12
Head and Neck Surgery (No Plastic)	9257	12
Hematology (Minor Surgery)	9163	7
Hematology	8978	3

A. Specialty Class Plan (Continued)

Physician/Surgeon Specialty	Code	Class
Hospitalist (Including ER)	9178	11
Hospitalist (No ER)	9179	5
Infectious Diseases (Minor Surgery)	9181	8
Infectious Diseases (No Surgery)	9180	4
Internal Medicine (Minor Surgery)	9182	8
Internal Medicine (No Surgery)	9183	6
Neonatology	8985	12
Nephrology (Minor Surgery)	9185	6
Nephrology (No Surgery)	9186	3
Neurology (Minor Surgery)	9187	8
Neurology (No Surgery)	9188	4
Neurosurgery	8923	22
Nuclear Medicine	8981	2
Obstetrics and Gynecology	8926	19
Occupational Medicine	8800	1
Oncology (Major Surgery)	9191	14
Oncology (Minor Surgery)	9189	6
Oncology (No Surgery)	9190	3
Ophthalmology (Major Surgery)	9025	3
Ophthalmology (Minor Surgery)	9024	3
Ophthalmology (No Surgery)	9023	2
Orthopedics (Minor Surgery)	9192	7
Orthopedics (No Surgery)	9193	4
Orthopedic Surgery (Including Spinal Surgery)	9037	20
Orthopedic Surgery (No Spinal Surgery)	9107	17
Otolaryngology (Minor Surgery)	9194	8
Otolaryngology (No Surgery)	9195	1
Otolaryngology (Surgery Cosmetic)	9196	16
Otolaryngology (Surgery Constructive)	9197	10
Pain Management (Advanced Procedures)	9198	21
Pain Management (Intermediate Procedures)	9200	18
Pain Management (Basic Procedures)	9199	13
Pain Management (No Surgery)	9236	7
Pathology (No Surgery)	9143	2
Pathology (Forensic)	9201	1
Pediatrics (Minor Surgery)	9145	8
Pediatrics (No Surgery)	9146	2
Perinatology	9019	21
Physical Medicine and Rehabilitation (Interventional)	9147	7
Physical Medicine and Rehabilitation (Non-Interventional)	9148	1

A. Specialty Class Plan (Continued)

Physician/Surgeon Specialty	Code	Class
Physician NOC (Minor Surgery)	9202	8
Physician NOC (No Surgery)	9203	2
Plastic Surgery	8939	16
Podiatry	9241	3
Preventive Medicine	9210	2
Psychiatry (All Other)	9242	2
Public Health Medicine	9214	2
Pulmonology	9215	6
Radiology (Oncology)	9218	3
Radiology (Interventional)	9217	8
Radiology (Diagnostic)	9216	6
Rheumatology	9054	2
Sports Medicine (No Surgery)	9220	4
Thoracic Surgery	8986	18
Trauma Surgery	9221	19
Urgent Care	9030	5
Urology (Major Surgery)	9224	10
Urology (Minor Surgery)	9222	8
Urology (No Surgery)	9223	3
Vascular Surgery	9012	19

Ancillary Specialty	Code	Class
Audiologist	9256	Х
Certified Registered Nurse Anesthetist	8703	C-1
Inhalation/Respiratory Therapist	9226	Х
Midwife	9165	N
Nurse Practitioner	8704	Z
Nutritionist/Dietician	9227	Х
Optometrist	9228	Y
Orthotist/Prosthetist	9229	Y
Physical/Occupational Therapist	9232	Y
Physician Assistant	8701	Z
Psychologist	9213	Z
Radiology Assistant	9164	Y

B. <u>Manual Rates</u>

Standard Claims Made Program Step Factors

Step Factors	
First Year	25%
Second Year	50%
Third Year	78%
Fourth Year	90%
Fifth Year (Mature)	100%

B. Manual Rates (Continued)

Physicians and Surgeons Rate Table

Mature Rates (Claims Made) \$1M / \$3M Limits

Class	Territory							
	1	2	3	4	5	6	7	8
1	\$15,401	\$13,938	\$13,214	\$11,751	\$11,027	\$9,564	\$7,377	\$8,101
2	\$20,632	\$18,672	\$17,702	\$15,742	\$14,772	\$12,812	\$9,883	\$10,852
3	\$29,059	\$26,298	\$24,933	\$22,172	\$20,806	\$18,046	\$13,919	\$15,285
4	\$31,965	\$28,928	\$27,426	\$24,389	\$22,887	\$19,850	\$15,311	\$16,814
5	\$33,418	\$30,243	\$28,673	\$25,498	\$23,927	\$20,752	\$16,007	\$17,578
6	\$35,161	\$31,821	\$30,168	\$26,828	\$25,176	\$21,835	\$16,842	\$18,495
7	\$38,648	\$34,977	\$33,160	\$29,489	\$27,672	\$24,001	\$18,513	\$20,329
8	\$42,426	\$38,396	\$36,402	\$32,371	\$30,377	\$26,347	\$20,322	\$22,316
9	\$46,204	\$41,814	\$39,643	\$35,254	\$33,082	\$28,693	\$22,132	\$24,303
10	\$49,981	\$45,233	\$42,884	\$38,136	\$35,787	\$31,038	\$23,941	\$26,290
11	\$54,922	\$49,704	\$47,123	\$41,905	\$39,324	\$34,106	\$26,307	\$28,889
12	\$61,314	\$55,490	\$52,608	\$46,783	\$43,901	\$38,076	\$29,370	\$32,251
13	\$67,417	\$61,012	\$57,844	\$51,439	\$48,270	\$41,866	\$32,293	\$35,461
14	\$73,519	\$66,535	\$63,080	\$56,095	\$52,640	\$45,655	\$35,216	\$38,671
15	\$80,784	\$73,110	\$69,313	\$61,638	\$57,841	\$50,167	\$38,696	\$42,492
16	\$88,049	\$79,684	\$75,546	\$67,181	\$63,043	\$54,678	\$42,175	\$46,314
17	\$97,638	\$88,363	\$83,774	\$74,498	\$69,909	\$60,633	\$46,769	\$51,358
18	\$109,843	\$99,408	\$94,245	\$83,810	\$78,648	\$68,213	\$52,615	\$57,777
19	\$124,663	\$112,820	\$106,961	\$95,118	\$89,259	\$77,416	\$59,714	\$65,573
20	\$134,253	\$121,499	\$115,189	\$102,435	\$96,125	\$83,371	\$64,307	\$70,617
21	\$165,927	\$150,164	\$142,365	\$126,602	\$118,804	\$103,041	\$79,479	\$87,278
22	\$205,738	\$186,193	\$176,523	\$156,978	\$147,308	\$127,763	\$98,548	\$108,218

Territory 1: Cook, Jackson, Madison, St. Clair and Will

Territory 2: Vermilion

Territory 3: Kane, Lake, McHenry and Winnebago

Territory 4: DuPage, Kankakee and Macon

Territory 5: Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle and Randolph

Territory 6: Grundy and Sangamon

Territory 7: Adams, Knox, Peoria and Rock Island

Territory 8: Remainder of the State

B. <u>Manual Rates (Continued)</u>

Non-Physician Healthcare Providers Rate Table (Claims Made)				
Ancillary Class	Separate Limits	Shared Limits		
N	30% of Class 20	15% of Class 20		
X	5% of Class 3	0% of Class 3		
Υ	15% of Class 3	0% of Class 3		
Z	10% of Class 3	4% of Class 3		
C – 1	15% of Class 6	10% of Class 6		

III. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule.

A. Part Time Physicians

- 1. A physician who is determined to be working 20 hours or less a week is considered a part time practitioner and is eligible for a reduction of 50% on the otherwise applicable rate for that specialty.
- 2. A Part Time Practitioner may include any practitioner in classes 1 through 10 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

B. Physicians in Training

- 1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:
 - a. First Year Resident (or Intern) 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.
 - Resident Various lengths of time depending upon medical specialty; three years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.
 - c. Fellow Follows completion of residency and is a higher level of training.

B. <u>Physicians in Training (Continued)</u>

- 2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.
- 3. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program.
- 4. The credit is not applied to the Extended Reporting Period Coverage.
- 5. The physician-in-training credit is 50% for 1st Year Resident; 40% for Resident; 30% for Fellow. No other credits are to apply concurrent with this rule.

C. New Physician

- 1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
 - a. Residency;
 - b. Fellowship program in their medical specialty;
 - c. Fulfillment of a military obligation in remuneration for medical school tuition;
 - d. Medical school or specialty training program.
- 2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.
- 3. A credit of 30% for first and second years and 20% for the third year will be applied. No other credits are to apply concurrent with this rule.

D. Physician Teaching Specialists

 Coverage is available for faculty members of an accredited training program. The coverage will <u>not</u> apply to any professional services rendered in the Insured's private practice. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program.

D. <u>Physician Teaching Specialists (Continued)</u>

- Coverage is available for the private practice of a physician-teaching specialist. The coverage will <u>not</u> apply to any aspect of the Insured's teaching activities.
 - a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.
 - b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.
 - c. No other credits are to apply concurrent with this rule.
 - d. The applicable percentages are based upon hours, up to 50%.

E. <u>Physician's Leave of Absence</u>

- A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, will be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.
- 2. This will apply retroactively to the first day of disability or leave of absence.
- 3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the Insured is only eligible for one application of this credit for an annual policy period.
- 4. Full suspension of insurance and premium is available for up to one year, subject to underwriting approval.

F. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the following schedule:

Claim Free Years	Credit
0	0%
1	2%
2	4%
3	6%
4	8%
5	10%
6	12%
7	14%
8	16%
9	18%
10+	20%

A claim for the purpose of this rule includes ALAE or indemnity payments on open or closed claims greater than or equivalent to 50% of the base rate, subject to a minimum threshold of \$10,000. For closed claims, the claims free period will be calculated and begins based on the date the claim was closed. For open claims, the claim free period will cease once the payment threshold is exceeded and will begin again once the claim is closed. For those insureds that have never had a claim, or not exceeded the threshold, the claims free period will begin on the date the physician began practicing medicine in the state, and/or following completion of residency or fellowship.

G. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review.

Schedule Rating Modifications, Subject to UnderwritingFor Individuals and Groups, Subject to Underwriting

1. The Company will consider all insureds for credits/debits:

1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the insured(s) is greater/less than the expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience +/- 10%	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies +/- 25%	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s), which understate/overstate the severity of the claim(s).
5. Management Control Procedures +/- 10%	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.
6. Number/Type of Patient Exposures +/- 10%	Size and/or demographics of the patient population, which influences the frequency, and/or severity of claims.
7. Organizational Size/Structure +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
8. Medical Standards, Quality and Claim Review +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees that meet to assure the quality of the healthcare services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation and Credentialing	The insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record Keeping Practices +/- 10%	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.
Maximum Modification: +/- 25%	

H. Experience Rating

- A group practice, consisting of two or more insureds, may receive a credit/debit based on the claim history. The claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:
 - a. Premiums paid
 - b. Number of claims
 - c. Incurred losses
 - d. Cause of such losses
 - e. Nature of practice
- 2. Such credits/debits shall apply on a one-year basis and will be subject to annual review.

I. Risk Management

1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.

J. Deductible Credits

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer up to (\$1M/\$3M). Deductibles are subject to approval by the Company based on financial statements to be submitted by the Insured and financial guarantees are required. The Company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

1. Individual Deductibles

Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit.

Indemnity	Only	Indemnity and ALAE		
Deductible Pe	er Claim	Deductible Per Claim		
\$5,000	2.5%	\$5,000	6.5%	
\$10,000	4.5%	\$10,000	11.5%	
\$15,000	6.0%	\$15,000	15.0%	
\$20,000	8.0%	\$20,000	17.5%	
\$25,000	9.0%	\$25,000	20.0%	
\$50,000	15.0%	\$50,000	30.5%	
\$100,000	25.0%	\$100,000	40.0%	
\$200,000	37.5%	\$200,000	55.0%	
\$250,000	42.0%	\$250,000	58.0%	

The following Individual Deductibles are available on a Per Claim/Aggregate Basis. Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

Indemnity Only		Indemnity and ALA	Æ
Per Claim/Aggrega	ate	Per Claim/Aggregate	
\$5,000/\$15,000	2.0%	\$5,000/\$15,000	5.5%
\$10,000/\$30,000	4.0%	\$10,000/\$30,000	10.5%
\$25,000/\$75,000	8.5%	\$25,000/\$75,000	19.0%
\$50,000/\$150,000	14.0%	\$50,000/\$150,000	29.5%
\$100,000/\$300,000	24.0%	\$100,000/\$300,000	43.0%
\$200,000/\$600,000	36.0%	\$200,000/\$600,000	53.5%
\$250,000/\$750,000	40.0%	\$250,000/\$750,000	56.5%

2. Group Deductibles

An optional deductible, which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a claim. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year. When the organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below. Group deductible amounts apply to primary premium up to \$1 M/3 M only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate		Number o	Maximum Credit		
(\$000)	2-19	20-40	41-60	61-100	
5/15	.020	.018	.015	.012	\$10,500
10/30	.038	.035	.030	.024	\$21,000
25/75	.084	.079	.070	.058	\$52,500
50/150	.145	.139	.127	.109	\$105,000
100/300	.234	.228	.216	.196	\$120,000
200/600	.348	.346	.338	.321	\$420,000
250/750	.385	.385	.381	.368	\$525,000

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per Claim/Aggregate		Number of Insureds			Maximum Credit
Deductible	2-19	20-40	41-60	61-100	
5/15	.029	.026	.021	.017	\$12,750
10/30	.068	.063	.054	.043	\$25,500
25/75	.119	.112	.099	.082	\$63,750
50/150	.186	.179	.163	.140	\$127,500
100/300	.258	.252	.239	.216	\$255,000
200/600	.396	.394	.385	.366	\$510,000
250 /750	.467	.467	.462	.446	\$637,500

K. Individual Risk Rating

A risk may be individually rated by submitting a filing to the Illinois Department of Insurance, in accordance with Section 155.18(b) (4) of the Illinois Insurance Code. The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual experience, location or dispersion of exposure, and shall apply to all risks under the same or substantially the same circumstances or conditions. We must list the standards by which variations in hazards or expense provisions are measured, in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

-END OF SECTION III-

SECTION IV

NORCAL Secured Protection Program

I. OVERVIEW

NORCAL Mutual Insurance Company (hereinafter "Company") offers individual physician or group premium modifications to physicians who fail to meet standard rating criteria for premium computation under Section III of NORCAL Mutual Insurance Company's Manual in order to afford physicians every reasonable opportunity to remain insured with an admitted standard insurer. The Secured Protection Program is an amendment to the NORCAL Mutual Insurance Company Manual currently approved in the state and is incorporated by reference in Section IV. The NORCAL Secured Protection Program (SPP) may be offered to new and renewal policies falling into this category. Qualifying circumstances include but are not limited to:

DEA License Suspension

Professional Misconduct

Successful Completion of Chemical Dependency Program

Adverse Claims Experience (Severity and/or Frequency)

Proctorship

Medical Board Sanctions or Fines

Unusual Practice Characteristics

Physical or Mental Health Impairments

Bare Exposure Period

Cosmetic Procedures Outside Scope of Formal Training

The majority of renewal business falling into this category is a result of higher than expected frequency and severity of claims. Coverage is offered to physicians who fall outside the parameters of the standard NORCAL program but do not warrant coverage in the non-standard market. Insureds who have unsuccessfully appealed an underwriting decision of non-renewal are also eligible for coverage under this program.

II. APPLICANT REFERRAL CRITERIA:

A. Eligibility-New Business

In lieu of declining a physician or group, the outlined surcharges on pages 6 through 8 of the NORCAL Mutual Insurance Company Manual <u>Section IV Part VIII. NORCAL Secured Protection Program Rating Formula</u> may be applied for a physician or group that does not meet the minimum underwriting guidelines established by the Company's Manual <u>Section III</u>.

B. Eligibility-Renewal Business

In lieu of nonrenewing a physician or group, the following surcharges may be applied for:

- 1. A physician or group whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or
- 2. A physician or group for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established by the Company's Manual <u>Section III</u>.

Surcharges are subject to the point ranges set forth on the Points Evaluation Worksheet (see pg. 11); surcharges of 50% to 400% will be applied as a percentage of the premium. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

The Company will grant individual consideration to New Solo Applicants (i.e. those not members of a group). A solo physician may not be appropriate for the SPP.

III. LENGTH OF INSURED'S REHABILITATION

Each Insured accepted in the SPP shall be surcharged up to a maximum of three years under the SPP, subject to meeting minimum requirements of rehabilitation.

IV. RATING APPROACH

Premium is calculated by applying the rate per physician on the rate pages from the NORCAL Manual under <u>Section III</u>, in accordance with each individual's medical classification, territory designation and standard claims made program step factors. This 'base rate' or un-discounted premium is then multiplied by the appropriate surcharge amount calculated on the Points Evaluation Worksheet (see pg. 11). No other surcharges will apply concurrently with a physician or group category surcharge. Surcharges range from +50% to +400%. If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claims free under the current NORCAL Mutual Insurance Company Manual <u>Section III (F.) Claim Free Credit Program</u>.

V. UNDERWRITING

Key factors considered in physician evaluation for the NORCAL Secured Protection Program (SPP) other than bare exposure is the probability and degree of rehabilitation. Underwriting will evaluate the nature of each claim to determine if it represents a pattern of poor judgment. Further, additional consideration is given to a physician affiliated with a group that can provide additional support, influence, and/or oversight. This is also due in part to the NORCAL philosophy and requirement that physicians practicing together must be insured by a common carrier (all or nothing rule). If the group otherwise has good experience, NORCAL strives to work with the group and the physician to reach a mutually beneficial agreement. The goals of the SPP are that:

- 1. A physician returns to or stays in the standard NORCAL program at a surcharge,
- 2. After three years becomes eligible to qualify for coverage under the standard rating rules, and
- 3. An entire group does not become uninsurable under the standard program due to the loss experience of one or two physicians.

It is foreseeable that a physician or physician group must be non-renewed based on an underwriting assessment that a group would be unable to resolve persisting issues resulting in continued losses within the three-year period.

A. <u>Coverage Modifications</u>

- 1. The only limits available to physicians in the program are \$1 million/\$3 million or state minimum requirement.
- 2. The applicable corporate limit of any physician in the SPP is a shared limit. No separate limit is available (See SPP01 Secured Protection Plan Endorsement).
- 3. Policies may contain specific procedure limitation exclusions and other exclusions, (See NORCAL Form A013 [Exclusion of Procedure Endorsement]) such as consent to settle, which will require the written agreement by the applicant prior to policy issuance.
- 4. Physicians may be required to carry an indemnity and claim expenses (Allocated Loss Adjustment Expenses [ALAE]) deductible at the discretion of the underwriter not to exceed a \$5,000 per physician per claim deductible with a \$15,000 deductible annual aggregate.)

B. Consent to Settle

Physicians insured under the NORCAL Secured Protection Program (SPP) are issued policies with endorsements restricting consent to settle. While insured in the SPP, consent to settle lies with the Company. A physician is expected to be rehabilitated and to return back to the standard program where he/she will regain the right to consent.

C. <u>Impaired Physicians</u>

An impaired physician is identified as one who is monitored by the physician's resident state's Physician Health Program, medical board or similar organization. Physicians may be required to go through a formal recovery program depending upon the degree/nature of the chemical dependency. Upon discharge from an approved program, the physician signs an agreement for regular monitoring, including random urinalyses. NORCAL will not insure physicians who do not allow us to obtain information from their treatment facility. This program also assists physicians suffering from mental disorders.

D. Prior Acts

Physicians entering the NORCAL Secured Protection Program (SPP) with at least two years of prior acts coverage from the standard NORCAL program shall carry over prior acts coverage as per the NORCAL Mutual Insurance Company Manual Section I Part XIV Prior Acts Coverage. Physicians with less than two years of prior acts coverage with NORCAL Mutual Insurance Company will receive careful consideration of physician or group details before offering prior acts coverage.

E. Imposed Deductibles

Deductibles may apply either to indemnity only or indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) not to exceed \$5,000 per claim with a \$15,000 deductible annual aggregate. An imposed deductible may be endorsed to address claims frequency. All deductibles require financial guarantees.

VI. PHYSICIAN OR GROUP MANAGEMENT

It will be mandatory for all insureds in the NORCAL Secured Protection Program (SPP) to successfully complete 10 hours of approved CME programs each year. SPP insureds are eligible for Physician or Group Management discounts offered under NORCAL Mutual Insurance Company Manual <u>Section III Part III Premium Modifications</u>.

Approved programs will include, but are not limited to, the following physician or group management and quality assurance topics:

- Specialty and Procedure Specific Programs
- I have experienced a Maloccurance
- The Best Deposition You Can Give
- EMR Vulnerabilities
- Online Offerings through MedRisk or other approved programs
- Use of medication flow sheet for patients taking multiple and or long-term medication, use of system to assure physician review of all reports (lab and x-ray consultations, etc.)
- Having patient completed health history questionnaire and use of SOAP or similar charting systems in a consistent, organized chart format.

VII. <u>INTERNAL LOGISTICS</u>

All NORCAL Secured Protection Program (SPP) insureds will be monitored through the NORCAL Mutual Insurance Company Software (MIC5). These insureds will be distinguished by a unique identifier (SPP), and underwritten under the electronic version of the Frequency & Severity Claims Schedule (see page 9) and Point Evaluation Worksheet (see page 11). Each program insured will be monitored on a quarterly basis. If deemed necessary by the underwriting manager, the physician may be required to have an onsite physician or group management review, continued drug testing, or extend proctorship at the expense of the physician.

VIII. NORCAL SECURED PROTECTION PROGRAM RATING FORMULA

POINTS – SCHEDULE A

	POINTS - SCHEDULE A	Rating						
	Claims Within The Last 10 Years From Date of Report							
	•							
Α.	Frequency and Severity Claims Schedule	Points						
		From Schedule						
В.	B. No Claims reported in the past five full years							
D.	Drug or Alcohol Impairment – Health	-100						
Α.	Has experienced drug, alcohol, or mental illness problems more than 5 years ago	50						
В.	Has experienced drug, alcohol, or mental illness problems with the past 5 years	75						
C.	Currently in treatment for unresolved substance abuse	150						
D.	Any relapse within the past 5 years	150						
E.	Physical or mental impairment that impacted physician's ability to practice medicine	100						
	safely	100						
	Government Agency Actions	1						
A.	Medical license in any state has been revoked	150						
B.	Medical license in any state has been suspended	100						
C.	Medical license has been placed on probation with restrictions on the type of services	75						
	he or she can provide							
D.	Medical license has been placed on probation for more than 5 years	75						
E.	Medical license has been placed on probation for 1 to 5 years	50						
F.	Medical license is under investigation	40						
G.	Public letter of reprimand, fine, citation, etc.	50						
Н.	Failure to report license investigation as required by affirmative duty language in	50						
	policy	400						
I.	During the preceding 5 year, DEA license has been revoked suspended or issued	100						
	with special terms or conditions, or license has been voluntarily surrendered or not renewed, other than normal nonrenewal license substantiated by physician							
	Terrewed, other than normal normal method substantiated by physician							
J.	Has been convicted or indicted of a criminal act, or has been found to be in a							
J.	violation of a civil statute, per event							
	Medically Related:							
	Within 5 years	100						
	More than 5 years	50						
K.	Medicare/Medicaid investigation	40						
L.	Loss of Medicare/Medicaid Privileges	50						
M.	Loss of any health insurance provider privileges	50						
	Note : Items A, B, C, D, E, F, G and H only applies per event							
	i.e., highest point value							
	Inappropriate Patient Contact	7-						
Α.	Proven with a single patient	75						
B.	Proven with more than one patient	150						
C.	Alleged with one or more patients	50						

POINTS – SCHEDULE A (Continued)

Medical Education A. Attended more than one medical school or a residency program due to actual or planned disciplinary action B. Residency complete at two or more facilities C. Started, but did not complete, a full residency program D. Did not begin a residency E. Has never received board certification Medical Records A. Records alterations with material change and intent B. Records alterations on a material change and intent C. Generally poor record keeping Informed Consent A. Incomplete consent obtained B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Revoke Privileges Revoke Privileges Notice Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility Frocedures A. Is performing a medical procedure that is in violation of policy exclusions and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty F. Is performing high physician or group procedures within his/her medical specialty F. Is performing high physician or group procedures within his/her medical specialty		POINTS – SCHEDULE A (Continued)	Dating
A. Attended more than one medical school or a residency program due to actual or planned disciplinary action B. Residency complete at two or more facilities C. Started, but did not complete, a full residency program D. Did not begin a residency E. Has never received board certification A. Records alterations with material change and intent B. Records alterations not a material change to records just cleaning up C. Generally poor record keeping Informed Consent A. Incomplete consent obtained B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Revoke Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions on the past 150 considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty		Medical Education	Rating
B. Residency complete at two or more facilities C. Started, but did not complete, a full residency program D. Did not begin a residency E. Has never received board certification A. Records alterations with material change and intent Records alterations not a material change to records just cleaning up C. Generally poor record keeping Informed Consent A. Incomplete consent obtained B. Lack of Informed consent A. Privileges - Any State (Hospital, Surgery Center, etc.) Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Revoke Privileges Revoke Privileges Revoke Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges a medical procedure that is in violation of policy exclusions D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 100	A.		50
C. Started, but did not complete, a full residency program 50 D. Did not begin a residency 50 E. Has never received board certification 50 Medical Records A. Records alterations with material change and intent 150 B. Records alterations not a material change to records just cleaning up 25 C. Generally poor record keeping 50 Informed Consent A. Incomplete consent obtained 25 B. Lack of Informed consent 50 Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) 50 B. Privileges have been suspended in the past 10 years (per event) 100 C. Privileges have been revoked in the past 10 years (per event) 150 D. Has been notified by facility of its intent to: 150 B. Restrict Privileges 30 Suspend Privileges 50 Revoke Privileges 100 Note: Only applies per Occurrence, i.e. highest point value E.		planned disciplinary action	
D. Did not begin a residency E. Has never received board certification Medical Records A. Records alterations with material change and intent B. Records alterations not a material change to records just cleaning up C. Generally poor record keeping Informed Consent A. Incomplete consent obtained B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. F. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 50 C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 100 Lis performing a procedure(s) outside his/her medical specialty 100	B.	•	50
E. Has never received board certification Medical Records A. Records alterations with material change and intent B. Records alterations not a material change to records just cleaning up C. Generally poor record keeping Informed Consent A. Incomplete consent obtained B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges So Revoke Privileges No Privileges at any facility No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 100	C.		50
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B. Records alterations not a material change to records just cleaning up C. Generally poor record keeping A. Incomplete consent obtained B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 50 C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty D. Is performing a procedure(s) outside his/her medical specialty 100			
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B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 50 C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 100			
Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 50 C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 100		•	
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years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. Rowed Privileges Too Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions Too Lis performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 100			
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Restrict Privileges 30 Suspend Privileges 50 Revoke Privileges 100 Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility 100 F. Currently undergoing peer review. 75 G. Notice of peer review received 50 Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 50 C. Is performing a procedure(s) not usual and customary to his/her medical specialty 50 D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 100	C.	Privileges have been revoked in the past 10 years (per event)	150
Suspend Privileges Revoke Privileges 100 Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility 100 F. Currently undergoing peer review. 75 G. Notice of peer review received 50 Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 50 C. Is performing a procedure(s) not usual and customary to his/her medical specialty 50 D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 100	D.	Has been notified by facility of its intent to:	
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 A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a procedure(s) not usual and customary to his/her medical specialty D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 	G.		50
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considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 100	C.	Is performing a procedure(s) not usual and customary to his/her medical specialty	50
	D.		150
	E.	Is performing a procedure(s) outside his/her medical specialty	100
	F.		100

POINTS – SCHEDULE A (Continued)

	POINTS - SCHEDULE A (Continued)	Datina
	Detient Cefety / Dhysisian as Croup Management	Rating
Λ.	Patient Safety / Physician or Group Management	400
Α.	Mandatory patient safety/physician or group management previously recommended and Failure to comply with physician or group management requirements	100
B.	Mandatory patient safety/physician or group management previously recommended and insured had initial compliance but no follow through	75
	Gaps in Medical Practice	
Α.	Gaps in medical practice of 6-months to 1-year duration	50
B.	Gaps in medical practice of 1-2 years duration.	100
C.	Gaps in medical practice greater than 2 years	150
	Payment History	
A.	Two or more late payments within the last three years.	100
B.	Two or more cancellations for non-payment of premium within the last three years.	150
	Other	
Α.	Uncooperative in Claims Handling	150
B.	Patient Load:	
	For Surgeons, 61-99 patients per week	50
	For Surgeons, 100 or more patients per week	100
	For all others, 101-149 patients per week	50
	For all others, 150 or more patients per week	100
C.	Advertising: If insured advertises his/her services on TV, newspapers, billboards or radio	25
D.	Uses collection agency that can file suit without insured's written consent	25
E.	Previous insurance history (bare, insolvent prior insurer or non-renewed)	100
F.	Claim experience of Associates, Partners or Corporation:	
	If one member with claim(s)	75
	If more than one member with claim(s)	100
	Favorable experience of group as a whole	-150
G.	For each claim or suit in which the physician breached the standard of care:	
	Mixed Reviews	50
	All Negative Reviews	100
	Admitted or Clear Liability	100
Н.	For two or more claims, suits or incidents arising out of the same or similar procedures or treatments	50
I.	Claim is too early in discovery period:	
	Surgical Class	-100
	Non-Surgical Class	-50
J.	For each claim or suit in which expert reviewers state the insured met the standard of care:	
	Surgical Class	-150
	Non-Surgical Class	-100
K.	High-physician or group surgical patient selection.	150
L.	Reinstatement of nonrenewal due to company election	150
M.	Loss Ratio in excess of 500%.	150
N.	Loss Ratio less than 100%.	-100
Ο.	Discrepancies between application answers/documents and verification	150

FREQUENCY AND SEVERITY CLAIMS SCHEDULE

							If Applicat	ole
Effecti	ive Date:			Review Date:				
		ı		thout Indemi	nity			
-	From:		То:	ALAE		Claim So	ore	
-		\$5,001		\$25	,000	Olaiiii Ol	1	
	9	\$25,001		\$50	,000		2	
_		550,001			,000		3	
-	\$1	100,001	Claima V		& up		4	
-				<u> Vith Indemni</u> nity + ALAE	ty			
-	From:		To:	IIILY T ALAL	С	laim Scor	<u>.</u>	
		\$1		\$25,00			4	
	\$2	5,001		\$50,00			5	
		0,001		\$100,00			6	
_		0,001		\$250,00			7	
-		0,001		\$500,00			8	
-		0,001		\$750,00 \$1,000,00			9 11	
_		0,001		- φ1,000,00 & u			13	
	Claimant Name	e Rep	oort Date	Indemnity	AL	AE	Total	Claim Score
Claim # 1	1	/	/	\$	\$			
Claim # 2			/	\$	\$			
Claim # 3		1	1	\$	\$			
Claim # 4		,	1	\$	\$			
Claim # 5		/	/	\$	\$			
Claim # 6		/	/	\$	\$			
Claim # 7		/	/	\$	\$			
Claim # 8		/	/	\$	\$			
Claim # 9	9	/	/	\$	\$			
Claim # 1	10	/	/	\$	\$			
							Total:	

Date:

Approved By:

FREQUENCY AND SEVERITY CLAIMS SCHEDULE (Continued)

Total Claim Score	Low Frequency Specialties						
	No. of Years w/ NORCAL						
	0 - 2	3 - 5	6 - 8	9 & up			
2	75	50	30	20			
3	100	75	55	45			
4	125	100	80	70			
5	150	125	105	95			
6	175	150	130	120			
7	200	175	155	145			
8	225	200	180	170			
9	250	225	205	195			
10	275	250	230	220			
11	300	275	255	245			
12	325	300	280	270			
13	350	325	305	295			
14	375	350	330	320			
15	400	375	355	345			
Total Claim Score		High Frequ	uency Specialt	ies**			
		No. of Y	ears w/ NORC	AL			
	0 - 2	3 - 4	5 - 6	7 & up			
3	75	50	30	20			
4	100	75	55	45			
5	125	100	80	70			
6	150	125	105	95			
7	175	150	130	120			
8	200	175	155	145			
9	225	200	180	170			
10	250	225	205	195			
11	275	250	230	220			
12	300	275	255	245			
13	325	300	280	270			
14	350	325	305	295			
15	375	350	330	320			

⁽¹⁾ As of Review Date

⁽²⁾ Add 25 points for each Total Claim Score above 15

^{**}Emergency Medicine, General Surgery, Gynecology, Neurosurgery
Obstetrics & Gynecology, Orthopedic Surgery, Plastic Surgery, Thoracic Surgery and Urology

POINT EVALUATION WORKSHEET

Insured: _				Po	Policy#:			
Effective Da	ate:			Review D	(If Applicable) Review Date:			
Criteria Claims Frequency Drug or Alcohol Impairment – Health Government Agency Actions Inappropriate Patient Contact Medical Education Informed Consent Privileges – Any State Procedures Physician or Group Management Gaps in Coverage Other Total Points				ints		Points		
oint Dongo	Curabarga	1 F	Daint Dange	Curcharge	7			
oint Range 0 – 100	Surcharge 0%	-	Point Range 301 – 325	Surcharge 90%	-	Point Range	Surcharge	
101-130	40%	-	326 – 350	100%	1	471 – 490	275%	
131 – 160	45%	-	351 – 370	125%		491 – 510	300%	
161 – 190	50%		371 – 390	150%	1	511 – 530	325%	
191 – 210	55%		391 – 410	175%	1	531 – 550	350%	
211 – 250	60%		411 – 430	200%		551 – 570	375%	

	i onit italigo	l Caronara.
	301 – 325	90%
	326 – 350	100%
	351 – 370	125%
	371 – 390	150%
	391 – 410	175%
	411 – 430	200%
	431 – 450	225%
	451 – 470	250%

Point Range	Surcharge
471 – 490	275%
491 – 510	300%
511 – 530	325%
531 – 550	350%
551 – 570	375%
571 – 590	400%
591+	Nonrenew

Completed By:	Date:	
, ,		
Approved By:	Date:	

-END OF MANUAL-

70%

80%

251 – 280

281 – 300

 SERFF Tracking #:
 NCMC-129207841
 State Tracking #:
 NCMC-129207841
 Company Tracking #:
 IL13015

State: Illinois Filing Company: NORCAL Mutual Insurance Company

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name:Illinois Rate/Rule Manual (INITIAL) 03/2014Project Name/Number:IL R/R Manual 03/2014/IL R/R Manual 03/2014

Supporting Document Schedules

Satisfied - Item:	Fundamenta nu Mara a anna di una					
	Explanatory Memorandum					
Comments:	Please see the attached.					
Attachment(s):	2013 09_NORCAL COVER LETTER (IL-R-R).pdf					
Item Status:						
Status Date:						
Bypassed - Item:	Form RF3 - (Summary Sheet)					
Bypass Reason:	N/A - New program in IL for NORCAL. No rate change.					
Attachment(s):						
Item Status:						
Status Date:						
Satisfied - Item:	Certification					
Comments:	Please see the attached.					
Attachment(s):	2013 09_IL CERTIFICATION.pdf					
Item Status:						
Status Date:						
Satisfied - Item:	Manual					
Comments:	Please see attached.					
Attachment(s):	IL Manual 03-2014 (N) (CHANGES TRACKED).pdf					
Item Status:						
Status Date:						
Bypassed - Item:	Request to Maintain Data as Trade Secret Information					
Bypass Reason:	N/A					
Attachment(s):						
Item Status:						
Status Date:						



September 17, 2013

Gayle Neuman
Illinois Department of Insurance
320 W Washington
Springfield, IL 62767

Re: NORCAL Mutual Insurance Company

NAIC #33200

Company Tracking Number: IL13015
SERFF Tracking Number: NCMC-129207841
Medical Professional Liability Insurance

Physician & Surgeon Medical Professional Liability Program "Me Too" Rate/Rule Filing (Medicus Insurance Company)

Proposed Effective Date: March 1, 2014

Dear Ms. Neuman,

This is the initial Rate/Rule filing from NORCAL Mutual Insurance Company in the state of Illinois. This filing is a "Me Too" filing. We are proposing to use the Medicus Insurance Company Rate/Rule Manual which was filed under SERFF Tracking and State Tracking Number MEIC-129000111 and approved on June 14, 2013.

Please let us know if we can provide further information.

Thank you for your consideration,

Jane Cundiff
Regulatory Compliance Analyst
NORCAL Mutual Insurance Company
512-879-5128
jcundiff@norcalmutual.com

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, <u>Neil Simons</u>, a duly authorized officer of <u>NORCAL Mutual Insurance Company</u>, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

I, <u>Bruce Williams</u>, a duly authorized actuary of <u>NORCAL Mutual Insurance Company</u>, am authorized to certify on behalf of <u>NORCAL Mutual Insurance Company</u> making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

Signature and Title of Authorized Insurance Company Officer

09/17/2013

Date

Signature, Title and Designation of Authorized Actuary

09/17/2013

Date

Insurance Company FEIN 94-2301054

Filing Number IL13015

Insurer's Address 560 Davis Street, Suite 200

City San Francisco

State CA

Zip Code 94111

Contact Person's:

Name and E-mail Jane M. Cundiff (jcundiff@norcalmutual.com)

Direct Telephone and Fax Number <u>512-879-5128</u>, Fax: <u>877-686-0558</u>



MANUAL

SECTION I

GENERAL RULES

I. PURPOSE OF MANUAL

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

II. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short-term policy period.

III. LOCATION OF PRACTICE

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. Consideration will be given to insureds practicing in more than one rating territory and/or state. The Territory Definitions are:

1. Counties: Cook, Jackson, Madison, St. Clair and Will

2. County: Vermilion

3. Counties: Kane, Lake, McHenry and Winnebago

4. Counties: DuPage, Kankakee and Macon

5. Counties: Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle and Randolph

III. LOCATION OF PRACTICE (Continued)

6. Counties: Grundy and Sangamon

7. Counties: Adams, Knox, Peoria and Rock Island

8. Remainder of State

IV. PREMIUM COMPUTATION

- A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.
- B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

V. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

VI. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

- A. Any amount involving \$.50 or over shall be rounded up to the next highest whole dollar amount: and
- B. Any amount involving \$.49 or less shall be rounded down to the next lowest whole dollar amount.

VII. ADDITIONAL PREMIUM CHARGES

- A. Prorate all changes requiring additional premium.
- B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

VIII. RETURN PREMIUM FOR MID-TERM CHANGES

- A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.
- B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

IX. POLICY CANCELLATIONS

- A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:
 - 1. A policy is canceled at the Company's request.
 - 2. The Insured is leaving a group practice, or
 - 3. Death, disability or retirement of the Insured.
- B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.
- C. Retain the Policy Minimum Premium when the Insured requests cancellation except when coverage is canceled as of the inception date.

X. POLICY MINIMUM PREMIUM

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of \$500.

Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

XI. PREMIUM PAYMENT PLAN

The Company offers the Insured the choice to pay in full or the following premium payment options:

- A. The monthly premium payment plan requires a minimum of 12.5% of the total premium to be paid on or before the inception/renewal date of the policy and the policyholder is billed 10 monthly installments of 8.33% and a final installment of 4.17%.
- B. The quarterly payment plan requires a 25% down payment and 3 quarterly installments of 25%.
- C. Our Automated Clearing House (ACH) option allows the Insured to have 12 equal monthly installments.

There are no extra fees associated with any premium payment plan.

XII. COVERAGE

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverage will be rated under Standard Claims-Made Rates.

XIII. LIMITS OF LIABILITY

The Basic Limits of Liability are \$1,000,000 per claim/\$3,000,000 annual aggregate. Credits and/or debits apply only to the \$1M/\$3M layer of the Limits of Liability

Individual Limits of Liability will be modified by the Increased Limits factor as applicable for the respective insureds and used to develop the applicable premium.

Liability Limit Factors					
Limits	Physicians	Surgeons			
\$500K/\$1M	0.719	0.719			
\$1M/\$3M	1.00	1.00			
\$2M/\$4M	1.36	1.55			
\$3M/\$5M	1.52	1.73			

XIV. PRIOR ACTS COVERAGE

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the Insured, subject to underwriting.

XV. EXTENDED REPORTING PERIOD COVERAGE

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

- A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.
- B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.
- C. The premium for the Extended Reporting Endorsement shall be the following Extended Reporting Endorsement rating factors applied to the premium found in Section III:

XV. EXTENDED REPORTING PERIOD COVERAGE (Continued)

 The Extended Reporting Endorsement factor from the table below is applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

Year	Factor
First Year	3.30
Second Year	3.15
Third Year	2.40
Fourth Year	2.00

- 2. For First Year Claims Made step, it is applied pro-rata.
- 3. For Second Year and all years of maturity, it is applied to the last year's (365 days) annualized premium from the date of cancellation.
- D. Premium is fully earned and must be paid in accordance with state statutes, promptly when due.
- E. The length of the Extended Reporting Period will be indefinite.
- F. Requirements for Waiver of Premium for Extended Reporting Period Coverage.
 - 1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.
 - 2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the Insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.
 - 3. The Reporting Period is unlimited.

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. DEFINITION

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

Professional Corporations, Partnerships and Associations

- B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:
 - 1. Are comprised of two or more physicians;
 - 2. Are organized as a legal entity;
 - 3. Maintain common facilities (including multiple locations) and support personnel; and
 - 4. Maintain medical/dental records of patients of the group as a historical record of patient care.

II. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations, limited liability companies, or other entity may be written with a separate limit of liability and shall be computed in the following manner:

The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. In order for the entity to be eligible for coverage, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company, and the remaining physicians must be insured by another professional liability program acceptable to the company.

II. PREMIUM COMPUTATION (Continued)

Number of Insureds	Percentages
1	25%
2-5	12%
6-9	10%
10-19	9%
20-49	7%
50 or more	5%

B. Vicarious Liability Charge: For each employed physician and ancillary staff not individually insured by the Company, a premium charge will be made at the same separate corporate percentage rate calculated above, to the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.

III. PREMIUM MODIFICATIONS

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III.

Physician & Surgeons	+/- 25%
Healthcare Providers	+/- 25%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers found in Section III.

SECTION III

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

I. <u>CLASSIFICATIONS</u>

- A. Physicians/Surgeons and Non Physician Health Care Providers
 - 1. Each medical practitioner is assigned a rate class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.
 - 2. The rate classes are found in Section III of this Manual.

B. Locum Tenens Physician

- Coverage for a physician substituting for an insured physician will be limited to cover <u>only</u> professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.
- 2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
- 3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

I. CLASSIFICATIONS (Continued)

D. Slot Rating

- Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those Insureds moving through the slot or position.
- The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.
- Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Company.

E. Per-Patient Visit Rating

- 1. Per-patient visit ratings are offered for Emergency Medicine and Urgent Care physicians.
- 2. The premium for the per-patient volume rated policy is determined by multiplying the appropriate premium for the specialty, the retroactive date, and the limits times the conversion factor indicated in the table below (this product is rounded to the nearest penny) times the annual patients visits. This number is then multiplied by (1 + the applicable corporate rate percentage outlined in Section II). The resulting product is the total premium for the policy.
- 3. Annual patient visits are reported by the Insured based on their actual historical visits, and projected for the next term. Annual patient visits are subject to audit and reconciliation at the end of the policy term.
- 4. The conversion factor below was determined by dividing one by the average patient visits for physicians in the specialty.

Specialty	Conversion Factor
Urgent Care	.000160
Emergency Medicine	.000278

5. Waiver of premium for the Extended Reporting Endorsement does not apply to the Per-Patient Visit Rating.

II. PREMIUM COMPUTATION DETAILS

A. Specialty Class Plan

The following classification plan shall be used to determine the appropriate rating class for each individual Insured.

Physician/Surgeon Specialty	Code	Class
Administrative Medicine	8901	2
Aerospace Medicine	9166	2
Allergy and Immunology	9108	1
Anesthesiology	8903	6
Anesthesiology (Pain Management)	9167	6
Cardiology (Minor Surgery)	9168	8
Cardiology (No Surgery)	9169	3
Colon and Rectal Surgery	8910	11
Critical Care Medicine	9022	8
Dentistry (All Other)	9171	3
Dermatology (Minor Surgery)	9042	3
Dermatology (No Surgery)	9043	2
Emergency Medicine (with Trauma)	9172	12
Emergency Medicine	9044	10
Endocrinology (Surgery)	9243	12
Endocrinology (Minor Surgery)	9122	4
Endocrinology	9013	2
Family Medicine (Including Obstetrics and C-Sections)	9113 9262	18
Family Medicine (Minor Surgery)	9110	9
Family Medicine (No Surgery)	9109	3
Family Medicine (Major Surgery including Obstetrics)	9113	12
Gastroenterology (Minor Surgery)	9174	8
Gastroenterology	8915	5
General Surgery	8919	15
Geriatrics (Major Surgery)	9177	13
Geriatrics (Minor Surgery)	9175	7
Geriatrics (No Surgery)	9176	3
Gynecology (Major Surgery)	9128	12
Gynecology (Minor Surgery)	9066	8
Gynecology (No Surgery)	9067	4
Hand Surgery	9027	12
Head and Neck Surgery (No Plastic)	9257	12
Hematology (Minor Surgery)	9163	7
Hematology	8978	3

A. Specialty Class Plan (Continued)

Physician/Surgeon Specialty	Code	Class
Hospitalist (Including ER)	9178	11
Hospitalist (No ER)	9179	5
Infectious Diseases (Minor Surgery)	9181	8
Infectious Diseases (No Surgery)	9180	4
Internal Medicine (Minor Surgery)	9182	8
Internal Medicine (No Surgery)	9183	6
Neonatology	8985	12
Nephrology (Minor Surgery)	9185	6
Nephrology (No Surgery)	9186	3
Neurology (Minor Surgery)	9187	8
Neurology (No Surgery)	9188	4
Neurosurgery	8923	22
Nuclear Medicine	8981	2
Obstetrics and Gynecology	8926	19
Occupational Medicine	8800	1
Oncology (Major Surgery)	9191	14
Oncology (Minor Surgery)	9189	6
Oncology (No Surgery)	9190	3
Ophthalmology (Major Surgery)	9025	3
Ophthalmology (Minor Surgery)	9024	3
Ophthalmology (No Surgery)	9023	2
Orthopedics (Minor Surgery)	9192	7
Orthopedics (No Surgery)	9193	4
Orthopedic Surgery (Including Spinal Surgery)	9037	20
Orthopedic Surgery (No Spinal Surgery)	9107	17
Otolaryngology (Minor Surgery)	9194	8
Otolaryngology (No Surgery)	9195	1
Otolaryngology (Cosmetic Surgery Surgery Cosmetic)	9196	16
Otolaryngology (Reconstructive SurgerySurgery Constructive)	9197	10
Pain Management (Advanced Procedures)	9198	21
Pain Management (Intermediate Procedures)	9200	18
Pain Management (Basic Procedures)	9199	13
Pain Management (No Surgery)	9236	7
Pathology (No Surgery)	8932 9143	2
Pathology (Forensic)	9201	1
Pediatrics (Minor Surgery)	9145	8
Pediatrics (No Surgery)	9146	2
Perinatology	9019	21
Physical Medicine and Rehabilitation (Interventional)	9147	7
Physical Medicine and Rehabilitation (Non-Interventional)	9148	1

A. Specialty Class Plan (Continued)

Physician/Surgeon Specialty	Code	Class
Physician NOC (Minor Surgery)	9202	8
Physician NOC (No Surgery)	9203	2
Plastic Surgery	8939	16
Podiatry	9241	3
Preventive Medicine	9210	2
Psychiatry (All Other)	9242	2
Public Health Medicine	9214	2
Pulmonology	9215	6
Radiology (Oncology)	9218	3
Radiology (Interventional)	9217	8
Radiology (Diagnostic)	9216	6
Rheumatology	9054	2
Sports Medicine (No Surgery)	9220	4
Thoracic Surgery	8986	18
Trauma Surgery	9221	19
Urgent Care	9030	5
Urology (Major Surgery)	9224	10
Urology (Minor Surgery)	9222	8
Urology (No Surgery)	9223	3
Vascular Surgery	9012	19

Ancillary Specialty	Code	Class
Audiologist	9256	Х
Certified Registered Nurse Anesthetist (Shared Limits)	8703	C-1
Inhalation/Respiratory Therapist	9226	Х
Midwife	9165	N
Nurse Practitioner	8704	Z
Nutritionist/Dietician	9227	Х
Optometrist	9228	Y
Orthotist/Prosthetist	9229	Y
Physical/Occupational Therapist	9232	Y
Physician Assistant	8701	Z
Psychologist	9213	Z
Radiology Assistant	9164	Y

B. <u>Manual Rates</u>

Standard Claims Made Program Step Factors

Step Factors	
First Year	25%
Second Year	50%
Third Year	78%
Fourth Year	90%
Fifth Year (Mature)	100%

B. Manual Rates (Continued)

Physicians and Surgeons Rate Table

Mature Rates (Claims Made) \$1M / \$3M Limits

Class	Territory							
	1	2	3	4	5	6	7	8
1	\$15,401	\$13,938	\$13,214	\$11,751	\$11,027	\$9,564	\$7,377	\$8,101
2	\$20,632	\$18,672	\$17,702	\$15,742	\$14,772	\$12,812	\$9,883	\$10,852
3	\$29,059	\$26,298	\$24,933	\$22,172	\$20,806	\$18,046	\$13,919	\$15,285
4	\$31,965	\$28,928	\$27,426	\$24,389	\$22,887	\$19,850	\$15,311	\$16,814
5	\$33,418	\$30,243	\$28,673	\$25,498	\$23,927	\$20,752	\$16,007	\$17,578
6	\$35,161	\$31,821	\$30,168	\$26,828	\$25,176	\$21,835	\$16,842	\$18,495
7	\$38,648	\$34,977	\$33,160	\$29,489	\$27,672	\$24,001	\$18,513	\$20,329
8	\$42,426	\$38,396	\$36,402	\$32,371	\$30,377	\$26,347	\$20,322	\$22,316
9	\$46,204	\$41,814	\$39,643	\$35,254	\$33,082	\$28,693	\$22,132	\$24,303
10	\$49,981	\$45,233	\$42,884	\$38,136	\$35,787	\$31,038	\$23,941	\$26,290
11	\$54,922	\$49,704	\$47,123	\$41,905	\$39,324	\$34,106	\$26,307	\$28,889
12	\$61,314	\$55,490	\$52,608	\$46,783	\$43,901	\$38,076	\$29,370	\$32,251
13	\$67,417	\$61,012	\$57,844	\$51,439	\$48,270	\$41,866	\$32,293	\$35,461
14	\$73,519	\$66,535	\$63,080	\$56,095	\$52,640	\$45,655	\$35,216	\$38,671
15	\$80,784	\$73,110	\$69,313	\$61,638	\$57,841	\$50,167	\$38,696	\$42,492
16	\$88,049	\$79,684	\$75,546	\$67,181	\$63,043	\$54,678	\$42,175	\$46,314
17	\$97,638	\$88,363	\$83,774	\$74,498	\$69,909	\$60,633	\$46,769	\$51,358
18	\$109,843	\$99,408	\$94,245	\$83,810	\$78,648	\$68,213	\$52,615	\$57,777
19	\$124,663	\$112,820	\$106,961	\$95,118	\$89,259	\$77,416	\$59,714	\$65,573
20	\$134,253	\$121,499	\$115,189	\$102,435	\$96,125	\$83,371	\$64,307	\$70,617
21	\$165,927	\$150,164	\$142,365	\$126,602	\$118,804	\$103,041	\$79,479	\$87,278
22	\$205,738	\$186,193	\$176,523	\$156,978	\$147,308	\$127,763	\$98,548	\$108,218

Territory 1: Cook, Jackson, Madison, St. Clair and Will

Territory 2: Vermilion

Territory 3: Kane, Lake, McHenry and Winnebago

Territory 4: DuPage, Kankakee and Macon

Territory 5: Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle and Randolph

Territory 6: Grundy and Sangamon

Territory 7: Adams, Knox, Peoria and Rock Island

Territory 8: Remainder of the State

B. Manual Rates (Continued)

Non-Physician Healthcare Providers Rate Table (Claims Made)			
Ancillary Class	Separate Limits	Shared Limits	
N	30% of Class 20	15% of Class 20	
X	5% of Class 3	0% of Class 3	
Υ	15% of Class 3	0% of Class 3	
Z	10% of Class 3	4% of Class 3	
C – 1	15% of Class 6	10% of Class 6	

III. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule.

A. Part Time Physicians

- 1. A physician who is determined to be working 20 hours or less a week is considered a part time practitioner and is eligible for a reduction of 50% on the otherwise applicable rate for that specialty.
- 2. A Part Time Practitioner may include any practitioner in classes 1 through 10 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

B. Physicians in Training

- Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:
 - First Year Resident (or Intern) 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.
 - Resident Various lengths of time depending upon medical specialty; three years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.
 - c. Fellow Follows completion of residency and is a higher level of training.

B. Physicians in Training (Continued)

- 2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.
- 3. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program.
- 4. The credit is not applied to the Extended Reporting Period Coverage.
- 5. The physician-in-training credit is 50% for 1st Year Resident; 40% for Resident; 30% for Fellow. No other credits are to apply concurrent with this rule.

C. New Physician

- 1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
 - a. Residency;
 - b. Fellowship program in their medical specialty;
 - c. Fulfillment of a military obligation in remuneration for medical school tuition;
 - d. Medical school or specialty training program.
- 2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.
- 3. A credit of 30% for first and second years and 20% for the third year will be applied. No other credits are to apply concurrent with this rule.

D. Physician Teaching Specialists

 Coverage is available for faculty members of an accredited training program. The coverage will <u>not</u> apply to any professional services rendered in the Insured's private practice. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program.

D. <u>Physician Teaching Specialists (Continued)</u>

- Coverage is available for the private practice of a physician-teaching specialist. The coverage will <u>not</u> apply to any aspect of the Insured's teaching activities.
 - a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.
 - b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.
 - c. No other credits are to apply concurrent with this rule.
 - d. The applicable percentages are based upon hours, up to 50%.

E. <u>Physician's Leave of Absence</u>

- A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, will be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.
- 2. This will apply retroactively to the first day of disability or leave of absence.
- 3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the Insured is only eligible for one application of this credit for an annual policy period.
- 4. Full suspension of insurance and premium is available for up to one year, subject to underwriting approval.

F. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the following schedule:

Claim Free Years	Credit
0	0%
1	2%
2	4%
3	6%
4	8%
5	10%
6	12%
7	14%
8	16%
9	18%
10+	20%

A claim for the purpose of this rule includes ALAE or indemnity payments on open or closed claims greater than or equivalent to 50% of the base rate, subject to a minimum threshold of \$10,000. For closed claims, the claims free period will be calculated and begins based on the date the claim was closed. For open claims, the claim free period will cease once the payment threshold is exceeded and will begin again once the claim is closed. For those insureds that have never had a claim, or not exceeded the threshold, the claims free period will begin on the date the physician began practicing medicine in the state, and/or following completion of residency or fellowship.

G. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review.

Schedule Rating Modifications, Subject to UnderwritingFor Individuals and Groups, Subject to Underwriting

1. The Company will consider all insureds for credits/debits:

1.	Historical Loss Experience +/- 25%	The frequency or severity of claims for the insured(s) is greater/less than the expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.	
2.	Cumulative Years of Patient Experience +/- 10%	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	
3.	Classification Anomalies +/- 25%	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.	
4.	Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s), which understate/overstate the severity of the claim(s).	
5.	Management Control Procedures +/- 10%	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	
6.	Number/Type of Patient Exposures +/- 10%	Size and/or demographics of the patient population, which influences the frequency, and/or severity of claims.	
7.	Organizational Size/Structure +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	
8.	Medical Standards, Quality and Claim Review +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees that meet to assure the quality of the healthcare services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.	
9.	Other Risk Management Practices and Procedures +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.	
10.	Training, Accreditation and Credentialing	The insured(s) exhibits greater/less than normal participation and support of such activities.	
11.	Record Keeping Practices +/- 10%	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.	
12.	Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.	
Max	Maximum Modification: +/- 25%		

H. Experience Rating

- A group practice, consisting of two or more insureds, may receive a credit/debit based on the claim history. The claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:
 - a. Premiums paid
 - b. Number of claims
 - c. Incurred losses
 - d. Cause of such losses
 - e. Nature of practice
- 2. Such credits/debits shall apply on a one-year basis and will be subject to annual review.

I. Risk Management

1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.

J. Deductible Credits

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer up to (\$1M/\$3M). Deductibles are subject to approval by the Company based on financial statements to be submitted by the Insured and financial guarantees are required. The Company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

1. Individual Deductibles

Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit.

Indemnity	Only	Indemnity and ALAE			
Deductible Pe	er Claim	Deductik	ole Per Claim		
\$5,000	2.5%	\$5,000	6.5%		
\$10,000	4.5%	\$10,000	11.5%		
\$15,000	6.0%	\$15,000	15.0%		
\$20,000	8.0%	\$20,000	17.5%		
\$25,000	9.0%	\$25,000	20.0%		
\$50,000	15.0%	\$50,000	30.5%		
\$100,000	25.0%	\$100,000	40.0%		
\$200,000	37.5%	\$200,000	55.0%		
\$250,000	42.0%	\$250,000	58.0%		

The following Individual Deductibles are available on a Per Claim/Aggregate Basis. Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

Indemnity Only		Indemnity and ALAE			
Per Claim/Aggrega	ate	Per Claim/Aggregate			
\$5,000/\$15,000	2.0%	\$5,000/\$15,000	5.5%		
\$10,000/\$30,000	4.0%	\$10,000/\$30,000	10.5%		
\$25,000/\$75,000	8.5%	\$25,000/\$75,000	19.0%		
\$50,000/\$150,000	14.0%	\$50,000/\$150,000	29.5%		
\$100,000/\$300,000	24.0%	\$100,000/\$300,000	43.0%		
\$200,000/\$600,000	36.0%	\$200,000/\$600,000	53.5%		
\$250,000/\$750,000	40.0%	\$250,000/\$750,000	56.5%		

2. Group Deductibles

An optional deductible, which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a claim. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year. When the organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below. Group deductible amounts apply to primary premium up to \$1 M/3 M only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate		Number o	Maximum Credit		
(\$000)	2-19	20-40	41-60	61-100	
5/15	.020	.018	.015	.012	\$10,500
10/30	.038	.035	.030	.024	\$21,000
25/75	.084	.079	.070	.058	\$52,500
50/150	.145	.139	.127	.109	\$105,000
100/300	.234	.228	.216	.196	\$120,000
200/600	.348	.346	.338	.321	\$420,000
250/750	.385	.385	.381	.368	\$525,000

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per Claim/Aggregate	Number of Insureds				Maximum Credit
Deductible	2-19	20-40	41-60	61-100	
5/15	.029	.026	.021	.017	\$12,750
10/30	.068	.063	.054	.043	\$25,500
25/75	.119	.112	.099	.082	\$63,750
50/150	.186	.179	.163	.140	\$127,500
100/300	.258	.252	.239	.216	\$255,000
200/600	.396	.394	.385	.366	\$510,000
250 /750	.467	.467	.462	.446	\$637,500

K. Individual Risk Rating

A risk may be individually rated by submitting a filing to the Illinois Department of Insurance, in accordance with Section 155.18(b) (4) of the Illinois Insurance Code. The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual experience, location or dispersion of exposure, and shall apply to all risks under the same or substantially the same circumstances or conditions. We must list the standards by which variations in hazards or expense provisions are measured, in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

-END OF SECTION III-

SECTION IV

Medicus NORCAL Secured Protection Program

I. OVERVIEW

Medicus NORCAL Insurance Company Mutual Insurance Company (hereinafter "Company") offers individual physician or group premium modifications to physicians who fail to meet standard rating criteria for premium computation under Section III of Medicus NORCAL Insurance Company Mutual Insurance Company's Manual in order to afford physicians every reasonable opportunity to remain insured with an admitted standard insurer. The Secured Protection Program is an amendment to the Medicus NORCAL Insurance Company Mutual Insurance Company Manual currently approved in the state and is incorporated by reference in Section IV. The Medicus NORCAL Secured Protection Program (SPP) may be offered to new and renewal policies falling into

this category. Qualifying circumstances include but are not limited to:

DEA License Suspension

Professional Misconduct

Successful Completion of Chemical Dependency Program

Adverse Claims Experience (Severity and/or Frequency)

Proctorship

Medical Board Sanctions or Fines

Unusual Practice Characteristics

Physical or Mental Health Impairments

Bare Exposure Period

Cosmetic Procedures Outside -Scope of Formal Training

The majority of renewal business falling into this category is a result of higher than expected frequency and severity of claims. Coverage is offered to physicians who fall outside the parameters of the standard Medicus-NORCAL program but do not warrant coverage in the non-standard market. Insureds who have unsuccessfully appealed an underwriting decision of non-renewal are also eligible for coverage under this program.

II. APPLICANT REFERRAL CRITERIA:

A. Eligibility-New Business

In lieu of declining a physician or group, the outlined surcharges on pages 6 through 8 of the Medicus-NORCAL Insurance Company Mutual Insurance Company Manual Section IV Part VIII. Medicus-NORCAL Secured Protection Program Rating Formula may be applied for a physician or group that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

B. <u>Eligibility-Renewal Business</u>

In lieu of nonrenewing a physician or group, the following surcharges may be applied for:

- 1. A physician or group whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or
- 2. A physician or group for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established by the Company's Manual <u>Section III</u>.

Surcharges are subject to the point ranges set forth on the Points Evaluation Worksheet (see pg. 11); surcharges of 50% to 400% will be applied as a percentage of the premium. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

The Company will grant individual consideration to New Solo Applicants (i.e. those not members of a group). A solo physician may not be appropriate for the SPP.

III. <u>LENGTH OF INSURED'S REHABILITATION</u>

Each Insured accepted in the SPP shall be surcharged up to a maximum of three years under the SPP, subject to meeting minimum requirements of rehabilitation.

IV. RATING APPROACH

Premium is calculated by applying the rate per physician on the rate pages from the Medicus NORCAL Manual under Section III, in accordance with each individual's medical classification, territory designation and standard claims made program step factors. This 'base rate' or undiscounted premium is then multiplied by the appropriate surcharge amount calculated on the Points Evaluation Worksheet (see pg. 11). No other surcharges will apply concurrently with a physician or group category surcharge. Surcharges range from +50% to +400%. If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claims free under the current Medicus NORCAL Insurance Company Manual Section III (F.) Claim Free Credit

V. UNDERWRITING

Key factors considered in physician evaluation for the Medicus NORCAL Secured Protection Program (SPP) other than bare exposure is the probability and degree of rehabilitation. Underwriting will evaluate the nature of each claim to determine if it represents a pattern of poor judgment. Further, additional consideration is given to a physician affiliated with a group that can provide additional support, influence, and/or oversight. This is also due in part to the Medicus NORCAL philosophy and requirement that physicians practicing together must be insured by a common carrier (all or nothing rule). If the group otherwise has good experience, Medicus NORCAL strives to work with the group and the physician to reach a mutually beneficial agreement. The goals of the SPP are that:

- A physician returns to or stays in the standard <u>Medicus NORCAL</u> program at a surcharge,
- 2. After three years becomes eligible to qualify for coverage under the standard rating rules, and
- 3. An entire group does not become uninsurable under the standard program due to the loss experience of one or two physicians.

It is foreseeable that a physician or physician group must be non-renewed based on an underwriting assessment that a group would be unable to resolve persisting issues resulting in continued losses within the three-year period.

A. Coverage Modifications

- 1. The only limits available to physicians in the program are \$1 million/\$3 million or state minimum requirement.
- The applicable corporate limit of any physician in the SPP is a shared limit. No separate limit is available (See SPP01 Secured Protection Plan Endorsement).
- Policies may contain specific procedure limitation exclusions and other exclusions, (See <u>Medicus NORCAL</u> Form A013 [Exclusion of Procedure Endorsement]) such as consent to settle, which will require the written agreement by the applicant prior to policy issuance.
- 4. Physicians may be required to carry an indemnity and claim expenses (Allocated Loss Adjustment Expenses [ALAE]) deductible at the discretion of the underwriter not to exceed a \$5,000 per physician per claim deductible with a \$15,000 deductible annual aggregate.)

B. Consent to Settle

Physicians insured under the Medicus NORCAL Secured Protection Program (SPP) are issued policies with endorsements restricting consent to settle. While insured in the SPP, consent to settle lies with the Company. A physician is expected to be rehabilitated and to return back to the standard program where he/she will regain the right to consent.

C. Impaired Physicians

An impaired physician is identified as one who is monitored by the physician's resident state's Physician Health Program, medical board or similar organization. Physicians may be required to go through a formal recovery program depending upon the degree/nature of the chemical dependency. Upon discharge from an approved program, the physician signs an agreement for regular monitoring, including random urinalyses. Medicus NORCAL will not insure physicians who do not allow us to obtain information from their treatment facility. This program also assists physicians suffering from mental disorders.

D. Prior Acts

Physicians entering the Medicus-NORCAL Secured Protection Program (SPP) with at least two years of prior acts coverage from the standard Medicus-NORCAL program shall carry over prior acts coverage as per the Medicus-NORCAL Insurance Company Mutual Insurance Company Manual Section I Part XIV

Prior Acts Coverage. Physicians with less than two years of prior acts coverage with Medicus-NORCAL Insurance Company Mutual Insurance Company will receive careful consideration of physician or group details before offering prior acts coverage.

E. Imposed Deductibles

Deductibles may apply either to indemnity only or indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) not to exceed \$5,000 per claim with a \$15,000 deductible annual aggregate. An imposed deductible may be endorsed to address claims frequency. All deductibles require financial guarantees.

VI. PHYSICIAN OR GROUP MANAGEMENT

It will be mandatory for all insureds in the Medicus-NORCAL Secured Protection Program (SPP) to successfully complete 10 hours of approved CME programs each year. SPP insureds are eligible for Physician or Group Management discounts offered under Medicus-NORCAL Insurance Company Manual Section III Part III Premium Modifications.

Approved programs will include, but are not limited to, the following physician or group management and quality assurance topics:

- Specialty and Procedure Specific Programs
- I have experienced a Maloccurance
- The Best Deposition You Can Give

- EMR Vulnerabilities
- Online Offerings through MedRisk or other approved programs
- Use of medication flow sheet for patients taking multiple and or long-term medication, use of system to assure physician review of all reports (lab and x-ray consultations, etc.)
- Having patient completed health history questionnaire and use of SOAP or similar charting systems in a consistent, organized chart format.

VII. INTERNAL LOGISTICS

- All Medicus NORCAL Secured Protection Program (SPP) insureds will be monitored through the
- Medicus NORCAL Insurance Company Mutual Insurance Company Software (MIC5). These insureds will be distinguished by
- a unique identifier (SPP), and underwritten under the electronic version of the Frequency & Severity Claims Schedule (see page 9) and Point Evaluation Worksheet (see page 11). Each program insured will be monitored on a quarterly basis. If deemed necessary by the underwriting manager, the physician may be required to have an onsite physician or group management review, continued drug testing, or extend proctorship at the expense of the physician.

VIII. MEDICUS NORCAL SECURED PROTECTION PROGRAM RATING FORMULA

POINTS – SCHEDULE A

	POINTS - SCHEDULE A	Rating
	Claims Within The Last 10 Years From Date of Report	
^		Delate
A.	Frequency and Severity Claims Schedule	Points From
		Schedule
B.	No Claims reported in the past five full years	-100
	Drug or Alcohol Impairment – Health	100
Α.	Has experienced drug, alcohol, or mental illness problems more than 5 years ago	50
B.	Has experienced drug, alcohol, or mental illness problems with the past 5 years	75
C.	Currently in treatment for unresolved substance abuse	150
D.	Any relapse within the past 5 years	150
E.	Physical or mental impairment that impacted physician's ability to practice medicine safely	100
	Government Agency Actions	1
Α.	Medical license in any state has been revoked	150
B.	Medical license in any state has been suspended	100
C.	Medical license has been placed on probation with restrictions on the type of services he or she can provide	75
D.	Medical license has been placed on probation for more than 5 years	75
E.	Medical license has been placed on probation for 1 to 5 years	50
F.	Medical license is under investigation	40
G.	Public letter of reprimand, fine, citation, etc.	50
Н.	Failure to report license investigation as required by affirmative duty language in policy	50
I.	During the preceding 5 year, DEA license has been revoked suspended or issued with special terms or conditions, or license has been voluntarily surrendered or not renewed, other than normal nonrenewal license substantiated by physician	100
J.	Has been convicted or indicted of a criminal act, or has been found to be in a violation of a civil statute, per event	
	Medically Related:	
	Within 5 years	100
	More than 5 years	50
K.	Medicare/Medicaid investigation	40
L.	Loss of Medicare/Medicaid Privileges	50
M.	Loss of any health insurance provider privileges	50
	Note : Items A, B, C, D, E, F, G and H only applies per event i.e., highest point value	
	Inappropriate Patient Contact	
Α.	Proven with a single patient	75
В.	Proven with more than one patient	150
C.	Alleged with one or more patients	50

POINTS – SCHEDULE A (Continued)

A. Attended more than one medical school or a residency program due to actual or planned disciplinary action B. Residency complete at two or more facilities C. Started, but did not complete, a full residency program D. Did not begin a residency E. Has never received board certification Medical Records A. Records alterations with material change and intent B. Records alterations not a material change to records just cleaning up C. Generally poor record keeping Informed Consent A. Incomplete consent obtained B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 5. C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty E. Is performing a procedure(s) outside his/her medical specialty		POINTS - SCHEDULE A (Continued)	Rating
A. Attended more than one medical school or a residency program due to actual or planned disciplinary action B. Residency complete at two or more facilities C. Started, but did not complete, a full residency program 5. D. Did not begin a residency E. Has never received board certification A. Records alterations with material change and intent B. Records alterations not a material change to records just cleaning up C. Generally poor record keeping Informed Consent Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is in violation of policy exclusions and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10. Is performing a procedure(s) outside his/her medical specialty		Medical Education	ivatiliy
C. Started, but did not complete, a full residency program D. Did not begin a residency E. Has never received board certification Medical Records A. Records alterations with material change and intent B. Records alterations not a material change to records just cleaning up C. Generally poor record keeping Informed Consent A. Incomplete consent obtained B. Lack of Informed consent Frivileges – Any State (Hospital, Surgery Center, etc.) Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10 11 12 13 14 15 16 17 17 18 18 19 19 10 10 10 11 11 11 12 13 14 15 15 16 17 17 18 19 19 10 10 10 10 10 11 11 11	Α.	Attended more than one medical school or a residency program due to actual or	50
D. Did not begin a residency E. Has never received board certification Medical Records A. Records alterations with material change and intent B. Records alterations not a material change to records just cleaning up C. Generally poor record keeping Informed Consent A. Incomplete consent obtained B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 5. Suspend Privileges A. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10. Is performing a procedure(s) outside his/her medical specialty	В.	Residency complete at two or more facilities	50
E. Has never received board certification Medical Records A. Records alterations with material change and intent B. Records alterations not a material change to records just cleaning up C. Generally poor record keeping Informed Consent A. Incomplete consent obtained B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges F. Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty E. Is performing a procedure(s) outside his/her medical specialty	C.		50
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B. Records alterations not a material change to records just cleaning up C. Generally poor record keeping A. Incomplete consent obtained B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a procedure(s) not usual and customary to his/her medical specialty E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty		Medical Records	
C. Generally poor record keeping	Α.	Records alterations with material change and intent	150
Informed Consent A. Incomplete consent obtained B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility Currently undergoing peer review. F. Currently undergoing peer review. A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 5. C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 1. C. Is performing a procedure(s) outside his/her medical specialty E. Is performing a procedure(s) outside his/her medical specialty	B.	Records alterations not a material change to records just cleaning up	25
A. Incomplete consent obtained B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Suspend Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Frocedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 50 C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10 11 12 13 14 15 16 17 18 19 19 19 10 10 10 10 10 10 10	C.	Generally poor record keeping	50
B. Lack of Informed consent Privileges – Any State (Hospital, Surgery Center, etc.) A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 5. C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10.		Informed Consent	
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A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 5. C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 100 110 110 110 110 110 110 1	B.	Lack of Informed consent	50
years (per event) B. Privileges have been suspended in the past 10 years (per event) C. Privileges have been revoked in the past 10 years (per event) D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions 5. C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 19. 19. 10. 10. 10. 10. 10		Privileges – Any State (Hospital, Surgery Center, etc.)	
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D. Has been notified by facility of its intent to: Restrict Privileges Suspend Privileges Revoke Privileges Revoke Privileges 100 Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a medical procedure that is in violation of policy exclusions 50 C. Is performing a medical procedure that is in violation of policy exclusions 51 C. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 100 110 110 110 110 110 110 1	B.	Privileges have been suspended in the past 10 years (per event)	100
Restrict Privileges Suspend Privileges Revoke Privileges 10 Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a procedure(s) not usual and customary to his/her medical specialty D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10	C.	Privileges have been revoked in the past 10 years (per event)	150
Suspend Privileges Revoke Privileges 10 Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Frocedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a procedure(s) not usual and customary to his/her medical specialty D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10 10 10 10 10 10 10 10 10 10 10 10 10	D.	Has been notified by facility of its intent to:	
Revoke Privileges Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a procedure(s) not usual and customary to his/her medical specialty D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10 11 12 13 14 15 16 17 17 18 19 19 10 10 10 10 10 10 10 10		Restrict Privileges	30
Note: Only applies per Occurrence, i.e. highest point value E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a procedure(s) not usual and customary to his/her medical specialty D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10		Suspend Privileges	50
E. No Privileges at any facility F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a procedure(s) not usual and customary to his/her medical specialty D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 100			100
F. Currently undergoing peer review. G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a procedure(s) not usual and customary to his/her medical specialty D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10		Note: Only applies per Occurrence, i.e. highest point value	
G. Notice of peer review received Procedures A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a procedure(s) not usual and customary to his/her medical specialty D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 15	E.	No Privileges at any facility	100
A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a procedure(s) not usual and customary to his/her medical specialty D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 12	F.	Currently undergoing peer review.	75
A. Is performing a medical procedure that is considered experimental but not directly dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a procedure(s) not usual and customary to his/her medical specialty D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 15	G.	Notice of peer review received	50
dangerous B. Is performing a medical procedure that is in violation of policy exclusions C. Is performing a procedure(s) not usual and customary to his/her medical specialty D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10			
C. Is performing a procedure(s) not usual and customary to his/her medical specialty D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10	A.		15
 D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 	B.	Is performing a medical procedure that is in violation of policy exclusions	50
considered dangerous E. Is performing a procedure(s) outside his/her medical specialty 10	C.	Is performing a procedure(s) not usual and customary to his/her medical specialty	50
	D.		150
	E.	Is performing a procedure(s) outside his/her medical specialty	100
	F.		100

POINTS – SCHEDULE A (Continued)

	FOINTS - SCHEDOLE A (Continued)	Rating
	Patient Safety / Physician or Group Management	<u> </u>
Α.	Mandatory patient safety/physician or group management previously recommended	100
	and Failure to comply with physician or group management requirements	
B.	Mandatory patient safety/physician or group management previously recommended	75
	and insured had initial compliance but no follow through	
	Gaps in Medical Practice	
A.	Gaps in medical practice of 6-months to 1-year duration	50
B.	Gaps in medical practice of 1-2 years duration.	100
C.	Gaps in medical practice greater than 2 years	150
	Payment History	
Α.	Two or more late payments within the last three years.	100
B.	Two or more cancellations for non-payment of premium within the last three years.	150
	Other	T
Α.	Uncooperative in Claims Handling	150
B.	Patient Load:	
	For Surgeons, 61-99 patients per week	50
	For Surgeons, 100 or more patients per week	100
	For all others, 101-149 patients per week	50
	For all others, 150 or more patients per week	100
C.	Advertising: If insured advertises his/her services on TV, newspapers, billboards or radio	25
D.	Uses collection agency that can file suit without insured's written consent	25
E.	Previous insurance history (bare, insolvent prior insurer or non-renewed)	100
F.	Claim experience of Associates, Partners or Corporation:	
	If one member with claim(s)	75
	If more than one member with claim(s)	100
	Favorable experience of group as a whole	-150
G.	For each claim or suit in which the physician breached the standard of care:	
	Mixed Reviews	50
	All Negative Reviews	100
	Admitted or Clear Liability	100
Н.	For two or more claims, suits or incidents arising out of the same or similar	50
	procedures or treatments	
I.	Claim is too early in discovery period:	
	Surgical Class	-100
	Non-Surgical Class	-50
J.	For each claim or suit in which expert reviewers state the insured met the standard of	
	care:	4-0
	Surgical Class	-150
	Non-Surgical Class	-100
K.	High-physician or group surgical patient selection.	150
L.	Reinstatement of nonrenewal due to company election	150
M.	Loss Ratio in excess of 500%.	150
N.	Loss Ratio less than 100%.	-100
Ο.	Discrepancies between application answers/documents and verification	150

FREQUENCY AND SEVERITY CLAIMS SCHEDULE

								If Applicat	ole
Effec	tive Da	ate:			Review Date:				
					thout Indemi	nity			
	Fron	1:			ALAE		Claim	Score	
			5,001		\$25	,000		1	
						,000		2	
					\$100			3	
		\$100	J,00 I	Claims V	Vith Indemni	<u>& up</u> t v		4	
	From: \$5,001 \$25,001 \$25,001 \$100,001 \$100,001 \$100,001 \$100,001 \$100,001 \$100,001 \$100,001 \$100,001 \$100,001 \$1,000,001 \$				nity + ALAE	-			
	Fron	1:			-		laim Sc	ore	
					\$25,00			4	
					\$50,00			5	
	\$50,001 \$100,001				\$100,000 6 \$250,000 7		<u>6</u> 		
				\$500,000 \$750,000 \$1,000,000			8 9 11		
		\$500,	001						
		\$1,000,	001		& u	р		13	
	(Claimant Name	Rep	ort Date	Indemnity	Al	LAE	Total	Claim Score
Claim #	1		/	/	\$	\$			
Claim #	2		/	/	\$	\$			
Claim #	3		/	/	\$	\$			
Claim #	4		/	/	\$	\$			
Claim #			/	/	\$	\$			
Claim #			/	/	\$	\$			
			/	/	\$	\$			
Claim #			/	/	\$	\$			
Claim #	8		,						
			/	/	\$	\$			
Claim #	9		1	/	\$	\$			

Date:

Approved By:

FREQUENCY AND SEVERITY CLAIMS SCHEDULE (Continued)

Total Claim Score	Low Frequency Specialties							
		No. of Years w/ NORCALMIC						
	0 - 2	3 - 5	6 - 8	9 & up				
2	75	50	30	20				
3	100	75	55	45				
4	125	100	80	70				
5	150	125	105	95				
6	175	150	130	120				
7	200	175	155	145				
8	225	200	180	170				
9	250	225	205	195				
10	275	250	230	220				
11	300	275	255	245				
12	325	300	280	270				
13	350	325	305	295				
14	375	350	330	320				
15	400	375	355	345				
Total Claim Score		High Frequ	uency Specialt	ies**				
		No. of Yea	rs w/ NORCAL	MIC				
	0 - 2	3 - 4	5 - 6	7 & up				
3	75	50	30	20				
4	100	75	55	45				
5	125	100	80	70				
6	150	125	105	95				
7	175	150	130	120				
8	200	175	155	145				
9	225	200	180	170				
10	250	225	205	195				
11	275	250	230	220				
12	300	275	255	245				
13	325	300	280	270				
14	350	325	305	295				
15	375	350	330	320				

⁽¹⁾ As of Review Date

⁽²⁾ Add 25 points for each Total Claim Score above 15

^{**}Emergency Medicine, General Surgery, Gynecology, Neurosurgery
Obstetrics & Gynecology, Orthopedic Surgery, Plastic Surgery, Thoracic Surgery and Urology

POINT EVALUATION WORKSHEET

Insured:				Policy#:			
Effective D	oate:		Review	(If Applicable) Review Date:			
Governmer Inappropria Medical Ed Informed C Privileges - Procedures Physician c Gaps in Co	cohol Impairment of Agency Actions ate Patient Conta- ucation onsent - Any State or Group Manage	s ct			Points		
Other		Total Po	ints				
oint Range	Surcharge	Point Range	Surcharge				
0 – 100	0%	301 – 325	90%		oint Range	Surcharge	
101-130	40%	326 – 350	100%		471 – 490	275%	
131 – 160	45%	351 – 370	125%		491 – 510	300%	
161 – 190	50%	371 – 390	150%		511 – 530	325%	
191 – 190 191 – 210	55%	391 – 410	175%		531 – 550	350%	
211 – 250	60%	411 – 430	200%		551 – 570	375%	
251 – 280	70%	431 – 450	225%		571 – 590	400%	
		1 701 700	220/0	1 1		.00,0	

-END OF MANUAL-

Date:

Date:

Completed By:

Approved By: